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ABSTRACT

The second of a series of four booklets on residential programing for the mentally retarded (MR) presents a developmental model for residential services based on the premise that MR persons are capable of growth, development, and learning. Architectural factors, staff resistance and financial considerations are described as impediments to appropriate residential services. The developmental model is based on three major assumptions: life is a process of change; human development proceeds in an orderly sequence; and the rate and direction of development can be influenced by physical, psychological, and social aspects of the environment. Discussed are goals of the model, the normalization principle which states that dealing with the retarded in a normal manner helps them develop as normal persons, and implications of the model for residential programs. Standards intended to be applicable to all facilities providing 24 hour programing services are considered including standards for admission of residents, resident living arrangements, grouping and organization of residents, resident programs, and training and education. (For related information, see EC 050 051, EC 050 053, and EC 050 054.) (GW)

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RESIDENTIAL PROGRAMMING FOR MENTALLY RETARDED PERSONS

EC 050 051E

A Developmental Model
for Residential Services

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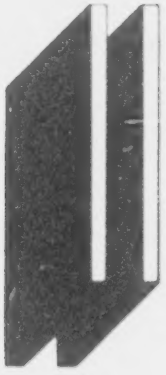

A Developmental Model
for Residential Services

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A Developmental Model for Residential Services

The philosophies and attitudes of residential personnel toward the capabilities and needs of retarded residents will directly affect the type and quality of training programs. They also provide a rationale for continuing practices, whether they are appropriate or inappropriate. This section addresses itself to the need for a workable residential service model, based on the premise that mentally retarded persons are capable of growth, development and learning.

DEVELOPMENT OF TRADITIONAL SERVICE MODELS

The purpose of the first institutions in the 1850's was to provide educational services for the mentally retarded. These facilities were actually schools in the true sense of the word, and long-term custodial care was not inherent in the plans for service. The schools were designed specifically to habilitate mentally retarded persons and return them to the community to live and work. In a few short years, however, the emphasis on services shifted from helping the mentally retarded to protecting society from them. There was a gradually increasing concern over the morality of the mentally retarded, their presumed criminal tendencies, inheritance of mental retardation, and eugenics. As these concerns increased, a cloud of pessimism and fear stifled the brief initial period of progress experienced by the first facilities. Mentally retarded persons were moved from populated areas where they could best be served, to isolated rural areas where they were rejected, abused, and subjected to inhuman treatment. By the turn of the century, mentally retarded persons were indicted for a wide array of social ills, and more and larger custodial institutions were endorsed by society. The emphasis on protecting society from mentally retarded persons reached its height immediately after the turn of the century, and the needs of the retarded person were completely overshadowed by society's frantic attempt to protect itself. Mentally retarded individuals were slighted even more by society's unwillingness to provide more than the essentials for survival in the institutional setting. Institutions had to be largely self-supporting in order for the inhabitants to survive; thus, mentally retarded persons were used as a captive work force. Such conditions continued through the early 1920's. By the end of the first quarter of the century, the treatment of, and the lack of services for, mentally retarded persons were subject to widespread criticism. However, due to a lack of readily apparent alternatives, the enormity of the established problems, and a general resistance to change, there was little or nothing done to improve conditions for institutionalized mentally retarded persons until the last decade.

NEED FOR A MODERN SERVICE MODEL

The way society sees the mentally retarded has been a major factor in determining the location, design and program orientation of residential facilities. These basic role perceptions may be thought of in terms of service models.

In this context, a service model for mentally retarded persons is a set of premises (or predictions) from which services are structured. In most cases, the total environmental setting reflects these predictions and there is no allowance for behavior or development contrary to such predictions. Thus, models generate self-fulfilling prophesies, i.e., the type of behavior or development predicted is encouraged and, generally, the expected results appear to be achieved.

Wolfensberger[1] describes seven models for services which are frequently found in institutions in this country. The first six are destructive in nature, and have resulted in inappropriate and dehumanizing approaches to residential care.

1) **The sick person** — mentally retarded persons are cared for in a hospital-like setting as it they were ill or diseased. Dependency, safety, comfort, cleanliness, and emphasis on the physical aspects of the "patient" are typical.
2) **The subhuman organism** — mentally retarded persons are viewed as being deviant to the extent of not being completely human, and are typically housed in an indestructible setting with locked doors. They are allowed minimum freedom and considered incapable of making decisions. Basic human rights are considered non-applicable.
3) **The menace** — mentally retarded persons are viewed as a threat because of their differences. They live in a prison-like setting. Few provisions for safety are provided. Care techniques may bear overtones of persecution. There is an emphasis on segregating the sexes.
4) **The object of pity** — mentally retarded persons are cared for as if they were suffering victims. Responsible functioning is de-emphasized. The retarded are sheltered, made comfortable, and emphasis is placed on making them "happy and contented".
5) **The burden of charity** — mentally retarded persons are viewed as being the responsibility of public charity, but it is assumed services will not exceed minimum expectations. The retarded are expected to be unduly grateful and suffer through intermittent hardships without complaint.
6) **The holy innocent** — mentally retarded persons are viewed as innocent, harmless childlike persons. Age is no criterion — even adults are treated as children.
7) **The developing person** — all mentally retarded persons,

[1]The origin and nature of our institutional models. In **Changing Patterns in Residential Services for the Mentally Retarded,** pp. 59-171.

regardless of the degree of retardation, are considered capable of growth, development and learning. The structure of the environment in which they live is also considered of prime importance in influencing the rate and direction of behavioral change.

Momentum of Old Service Models

Despite the rather impressive growth of knowledge and technology in the field of mental retardation, several factors have perpetuated destructive service models and have impeded the implementation of appropriate residential services.

Architectural factors. The physical aspects of institutions have provided momentum for the continuation of long-outmoded service approaches. The appearance of the physical plant of most public institutions conveys an unspoken message to the employees and residents which greatly inhibits the adoption of service models which emphasize the humanness and dignity of mentally retarded persons. The physical arrangements of facilities thus have a profound effect upon the role relationships between residents and staff. The creation of separate facilities for residents and staff (e.g., lounge areas and dining rooms) only serves to create additional barriers to meaningful staff-resident relationships. Large groups of people in massive, impersonal, and sterile settings promote loss of individual identity, regimentation, dependency, and child care practices for the total group which tend to accommodate the least capable members.

Staff resistance. Discrepancies between potential and actual services continue because of the threatening implications of change for the institutional staff. Implementing modern service models requires retraining of personnel, reorganization of staff, delegation of authority and responsibility, and, in many cases, a complete reversal of attitudes toward residents. Since modern program service models require constant planning, change, and flexibility, such changes may be especially threatening to the institutional administrative and mid-management staff. Change may also appear to threaten staff members working directly with the institution's residents. That is, direct care personnel may fear intensive programming will lead to increased supervision, more stringent work evaluation, and the assignment of greater and more specific responsibilities for the education, training, and supervision of residents. In effect, the adoption of modern service models would increase the complexity of the total institutional picture, thus creating more responsibility for the institutional staff and eliminating the security which may emanate from an established, simple, custodial approach to mental retardation.

Financial considerations. A critical shortage of funds has been a major obstacle in the implementation of sound training programs. Administrators of public residential facilities are faced with massive

problems when existing budgets do not provide for a sufficient number of direct care personnel. Furthermore, salaries for these positions are non-competitive in terms of the skilled labor market. Although inadequate financing is a very real problem, in most instances staff can be redeployed to maximize the impact of their efforts upon resident programming. In addition, a number of innovative and relatively inexpensive modifications can usually be made in a large facility to reduce a dehumanizing atmosphere.

However, concern over increased budgets, modifications of buildings, and supplementation of staff also impedes progress and overshadows the major issue: changing the basic relationship between the institutional staff and the mentally retarded residents. Modern buildings with homelike exteriors and interior furnishings would promote maximization of the humanness and dignity of mentally retarded persons. Still, unless the attitude of the staff coincides with the message implied in the structure of the buildings, conditions will not be greatly improved.

Residential services have undergone little significant change since the first institutions were built because the general public has been essentially unaware of the plight of retarded persons. Unfortunately, there is an apparent lack of true concern for the welfare of the retarded. Institutions and their services reflect public attitudes and respond to public pressures.

The developmental model is considered by Wolfensberger to be the most desirable approach to mental retardation. Of the seven which he describes, the developmental model is the only one which does not result in a dehumanizing approach to mental retardation.

The developmental model has recently been expanded (Roos, Patterson and McCann, 1971) to the extent that it can now serve as a basis for sound residential programming.

Basic Assumptions of the Developmental Model

The developmental model is based upon three primary assumptions:

1) **Life as change** — man, like other life forms, is in a state of change from the time of conception until death. The assumption that mentally retarded persons are often fixed or unchanging physically and psychologically is, in effect, the same as denying that mentally retarded persons are alive.
2) **Sequential development** — the development of human beings progresses in a sequential, orderly, and predictable manner. Each sequence of development serves as an introduction for more or less complex functioning. Thus, developmental sequences can be identified and used in planning programs and assessing progress.
3) **Modifiable development** — the rate of direction of development are influenced by the interaction of many internal and external factors, including inherited characteristics, health, and the external environmental setting. The rate and direction of development can be influenced through residential training by utilizing and controlling certain physical, psychological, and social aspects of the environment.

Goals of the Developmental Model

The primary goal of programs for the mentally retarded should be to increase the adaptive behavior of the individual by modifying the rate and direction of behavioral change. Mentally retarded persons should be approached from the standpoint of being capable of growth, learning, and development. Moreover, they should be considered as being in a state of constant change which can be significantly influenced by conditions imposed within the environmental setting.

Goals of residential programming, based on the developmental model, should be designed to meet three basic criteria for promoting the development of adaptive behavior:

1) **Are programs designed to increase resident's control over the environment?** Residential programs should be aimed at enabling the mentally retarded person to develop an increas-

ing degree of control over his environment, including other individuals and himself. Control over the environment implies that the retarded person must have the option for alternative choices (e.g., in matters of food, clothing and recreational and social activities), as well as the freedom to explore and interact with his environment.

2) **Do programs increase the complexity of resident behavior?** Programming should be designed to gradually produce more complex behavior patterns which, in turn, increases the individual's capacity to cope with his environment. This should be as basic as teaching a child to be fed with a spoon rather than being bottle or tube fed. On a more complex level, the mentally retarded person should progress from using a prepared tray to participating in family-style eating which requires serving himself at the table and determining the size of his portions.
3) **Are the human qualities of residents maximized?** The last, and probably the most important criterion for selecting program goals is that of maximizing the retarded person's human qualities, i.e., those qualities which are designated as culturally "normal" or "human". Social skills should receive considerable attention at all levels of development, since they increase the individual's human qualities.

These criteria for selecting program goals apply to all mentally retarded persons, regardless of current level of functioning.

The Normalization Principle

The normalization principle (Nirje, 1969) is one strategy for maximizing human qualities. This approach advocates furnishing the retarded with patterns of life which are as much like the normal life style as possible. Much emphasis has been placed, and quite correctly, on homelike settings. The normalization principle is one **technique** (among others) for reaching program goals. It assumes that by dealing with the retarded in a normal manner, they will tend to develop as normal persons.

Some features of a normalized environment would be:

Normal rhythm of day — daily rhythm is the same for the mentally retarded person as the nonretarded person. The retarded individual gets up, dresses, and goes to bed at a normal time. Meal times are normal as in a family situation.

Normal routines — the places for work, recreation, education, etc., are not the same as those where the retarded person lives. The purpose of the building in which the person lives is the same as that of a normal home.

Normal rhythm of the year — mentally retarded persons are afforded the opportunity to observe special events, holidays, and birthdays. Vacations away from the institutional setting are also meaningful to retarded persons.

Normal developmental experiences — mentally retarded persons progress through the developmental stages of childhood, adolescence, adulthood, and senility. Within each stage, different needs are emphasized. There are also different degrees of independence within each stage. These normal stages, although delayed in varying degrees, should be recognized and provided for, and the retarded person should not be subjected to a socially imposed eternal childhood.

Also inherent in the normalization principle is the opportunity to make choices and decisions, live in a heterosexual world, be afforded basic financial privileges, and live in home settings which are considered normal in size.

Particular emphasis is placed on providing a homelike small group setting. Such facilities should be located in the mainstream of society where the mentally retarded person will have an opportunity to learn, develop, and grow with his non-retarded peers. He should be taught to live in, and cope with, the community setting in as normal a way as possible.

For a more detailed discussion of the normalization principle, the reader is referred to the President's Committee on Mental Retardation monograph, **Changing Patterns in Residential Services for the Mentally Retarded.**

Although the normalization principle is extremely useful in many situations, the fact that a technique is normative does not guarantee that it is the most effective. The developmental model suggests that program effectiveness should be gauged by the degree to which goals are reached rather than by the degree to which procedures are culturally normative. In some cases, normative procedures may fail to foster desirable behavior, whereas specialized procedures may accomplish desired goals. For example, an "automated environment" (including such specialized equipment as automatic food dispensers and toilet facilities) may be more effective in increasing the independence of markedly retarded persons. Thus, normalizing procedures should be used **unless** specialized approaches are proven to be more effective in accomplishing developmental goals.

Implications of the Developmental Model for Residential Programs

The primary implication of the developmental approach is that programs oriented toward the individual and program goals should be dynamic and individually defined. Specific goals should be determined by observation of the individual resident's behavior and his current stage of development. Program goals for the group (i.e., increasing the complexity of behavior, increasing human qualities, increasing control over the environment) are appropriate, but the methods used to achieve these goals should be applied on an individual basis.

Equally important is the implication that the rate and direction of behavioral change in relation to specific goals will constantly be re-evaluated in order that the resident may progress at the maximum possible rate.

Developmental programming is not limited to the early phases of the life cycle, but is applicable to all stages, including old age. During the later stages of life, or in cases involving organic deterioration, goals should be selected in terms of decelerating negative changes, while changes considered to be desirable are selected for acceleration. For example, a person afflicted with progressive paralysis of the legs should be helped to retain maximum muscle control (decelerating muscle atrophy and loss of functions) while learning new skills involving the use of mechanical devices, such as a wheelchair and crutches (accelerating new behaviors).

STANDARDS FOR RESIDENTIAL FACILITIES

Background of Standards

A national planning committee on accreditation of residential centers for mentally retarded persons was organized in 1966 by the National Association for Retarded Children, the American Association on Mental Deficiency, the American Psychiatric Association, the Council for Exceptional Children, the United Cerebral Palsy Association, and the American Medical Association (Accreditation Council for Facilities for the Mentally Retarded, 1971). In 1969 the five sponsoring agencies formed the Accreditation Council for Facilities for the Mentally Retarded in order to establish a national, voluntary program of accreditation to improve the level of services provided for all mentally retarded persons.

Formulation of Standards

Standards for residential facilities were developed by twenty-two committees composed of 200 individuals representing all professional disciplines necessarily involved in providing adequate services for mentally retarded persons. The standards are intended to be applicable to all facilities -- public and private, large and small -- which provide twenty-four hour programming services. They are also designed to be relevant to both institutional and non-institutional models for the delivery of residential services. Providing each resident with the services which will enable him to attain maximum physical, intellectual, emotional, and social development is emphasized. The general and special rights of mentally retarded persons are also emphasized. The implementation of these standards began in late 1971. The standards will, of course, be subject to ongoing review and revision so that they continue to reflect the most current knowledge in the field of mental retardation.

The following statements have been based on, or taken from, standards developed by the Accreditation Council for Facilities for the Mentally Retarded, adopted May 5, 1971.

Policies and Practices of Residential Facilities

The ultimate goal of the residential facility must be to maximize the human qualities of every resident. Services should, therefore, be based on the developmental model in which the rate and direction of developmental change are influenced by increasing control over the environment, increasing the complexity of behavior, and developing behaviors appropriate to the person's stage in the life cycle, in relation to cultural and local norms.

The facility must have a written outline of the philosophies, objectives, and goals which it is striving to achieve. Such an outline will be made available to parents, the public and staff. It should

include concepts of the rights of the residents, the facility's relationship to the community, its relationship to the parents of its residents, and goals for the residents.

The facility must have a manual of practices and procedures describing methods, forms, processes, and sequences of events being followed to achieve stated objectives and goals.

The facility must plan for reviews and modifications to maintain consistency in its philosophies, objectives and goals. The facility's practices must also be reviewed periodically to ensure consistency with its stated philosophies, objectives and goals.

The facility must have a description of services for residents, available to the public, including:

1) information concerning the groups served,
2) a plan for grouping residents into programmed living units,
3) pre-admission and admission services,
4) diagnostic and evaluation services,
5) means for programming of residents in accordance with individual needs,
6) means of implementation of programs through clearly designated responsibility,
7) therapeutic and developmental environment provided the resident, and
8) release and follow-up services and procedures.

In its effort to intergrate residents to the greatest extent with the community population, the facility should extensively or completely use general and specialized community facilities and services such as public schools, hospitals, recreation resources, and vocational or job opportunities.

The facility must provide for meaningful and extensive consumer-representative and public participation by their involvement in policy-making, decision-making, and evaluation of residential services.

Standards for Admission of Residents

Before admission, service needs of the mentally retarded person must be defined without regard to the actual availability of the desired options. When group placement is not the optimal measure, but must be recommended or implemented, its inappropriateness should be clearly acknowledged and plans initiated for the active exploration of other alternatives.

A comprehensive evaluation covering physical, emotional, social, and cognitive factors of the prospective resident must be carried out by an interdisciplinary evaluation team prior to the final acceptance of a person for admission.

Parents must be counseled prior to admission, on relative advantages and disadvantages of the residential services under consideration. Prior to admission, the parents or guardians and the prospective resident should visit the facility and the living unit in

which the person is likely to be placed. Alternative programs of care, treatment, and training should be investigated and weighed, and the deliberations and findings recorded, before a person is admitted to the facility.

The need for removing a retarded person from his home must not be automatically equated with placement in a residential facility, and the possibility of foster home placement should be explored. An individual must not be admitted to the facility unless his needs can be met and he can benefit from its programs. The number admitted to the facility must not exceed its rated capacity and its provisions for adequate programming.

Within the period of one month after admission there must be a review and updating of the preadmission evaluation, a prognosis which can be used for programming and placement, and a comprehensive evaluation. An individual program plan must be made by an interdisciplinary team with participation of direct care personnel. An interpretation of this evaluation in action terms must also be made to the direct care personnel and the special services responsible for carrying out the program.

Standards for Resident Living Arrangements

The functional arrangements of the home must be simulated in designing the interior of living units, unless it has been demonstrated that other arrangements are more effective in maximizing the human qualities of the residents. Within the living unit, space must be arranged to permit residents to participate in different kinds of activities, both in groups and singly. There must be a minimum of eighty square feet of living, dining and activity space for each resident.

Bedrooms within the living units must be on, or above, street level. They should accommodate from one to four residents and be away from activity and programming areas. Approximately sixty square feet per resident must be provided in multi-sleeping rooms, and eighty square feet per person in single rooms. Where partitions define each bedroom, these partitions must extend from the floor to the ceiling. Doors in bedrooms should not have vision panels and should not be lockable except in cases where residents are permitted to lock their own bedroom doors as a part of their program. Also, in the bedroom area, provisions should be made for residents to mount pictures on the walls, have flowers, art work and other decorations. Each resident must have a separate bed equipped with a clean, comfortable mattress, and bedding appropriate for local weather conditions. Each resident must have appropriate individual furniture in which his personal possessions, play equipment, or individually prescribed prosthetic equipment might be placed.

Toilet areas, clothes closets, laundry hampers, etc., must be located so as to facilitate training toward maximum self-help by resi-

dents, including severely and profoundly retarded and multiple handicapped persons. Unless specifically contraindicated by program needs, toilets and showers must provide for individual privacy by use of partitions and doors. Commodes, showers, baths, and lavatories must approximate normal patterns found in private homes. Commodes, bathing, and toileting appliances must be equipped for use by the physically and/or psychologically handicapped, when these residents are served by the unit. Within each unit there must be at least one commode of appropriate size for each four residents, and at least one commode must be properly adapted to wheelchair residents. Each commode must be equipped with a toilet seat with accessible toilet tissue. There must be at least one lavatory for each six residents, and at least one tub or shower for each eight residents.

Standards for Grouping and Organization of Residents

Living unit components, or groupings, must be small enough to ensure the development of a meaningful and interpersonal relationship among residents and between residents and staff. The resident living unit should house both male and female residents and should accommodate not more than sixteen residents. Deviations from this size must be justified by improving the program needs of the residents being served.

Residents within a living unit must be grouped into program groups wherein there would be no more than eight residents in each group. Deviations from this size must be justified only on the basis of improving the program needs of the residents.

In relation to the training and education of the residents, a specific person having the responsibility for providing a structured developmental program of physical care, training, and recreation must be assigned to each program group.

Residents of grossly different ages, developmental levels, and social needs should not be housed in close physical or social proximity except to promote the growth and development of all those housed together. However, multi-handicapped residents must not be segregated from peers with comparable social and intellectual development on the basis of additional handicaps.

Standards for Resident Programs

The ultimate goal of the residential facility should be to maximize the human qualities of each resident it serves. Implementation of this goal should be at the living unit level.

The living unit staff. There must be sufficient, appropriately qualified, and adequately trained personnel to conduct the residential living programs in accordance with the standards specified.

The primary responsibility of the living unit staff, therefore, should be to devote their full attention to the care and development of the residents. Their responsibilities should also include

training residents in activities of daily living and the development of self-help skills. The development and maintenance of a warm, family, and homelike environment should also be the result of efforts of the living unit staff. Appropriate provisions should be made to ensure that the efforts of the staff are not diverted from these responsibilities by excessive housekeeping and clerical duties.

The titles applied to the indviduals who directly interact with the residents in the living units should be appropriate to the group of residents with whom they work and the kind of interaction in which they engage. Personnel who staff the living units may be referred to by a number of terms, such as attendants, child care workers, or cottage parents. The term psychiatric aides may be appropriate for employees serving the emotionally disturbed, but not for employees in a cottage of well-adjusted children. The title of child care worker may be appropriate for an employee in a nursery school group but not for an employee in an adult group. Nurses' aides are appropriate for employees serving sick residents but not well ones.

The resident living staff may not be supplemented by resident workers involved in the feeding, clothing, bathing, training, education, or supervision of other residents unless these workers have been specifically evaluated, possess the necessary skills, and have adequate judgment required for assigned responsibilities, and are adequately supervised.

The team approach. Members of the living unit staff from all shifts must participate with an interdisciplinary team on appropriate referral, planning, initiation, coordination, implementation, follow-through, monitoring, and evaluation in the care and development of the residents. Specific evaluations and program plans emanating from the interdisciplinary team for each resident must be available to the direct care staff and reviewed by members of the interdisciplinary team at least monthly.

Activity schedules for each resident must be available to the direct care staff and be carried out daily. Such schedules must not permit "dead time" of unscheduled activity for more than one hour continuous duration, but should allow for free individual and group activities, with appropriate materials, as specified by the program team.

Standards for Training and Education

The facility must provide all its residents with habilitation or rehabilitation services which include the establishment, maintenance, and implementation of those programs that will ensure the optimal development or restoration of each resident physically, psychologically, socially, and vocationally.

Mealtime and nutrition. Residents' meal times will be on a schedule comparable to the non retarded population of the community.

All residents, including the mobile non-ambulatory, will eat or be fed in dining rooms equipped with tables, chairs, eating uten-

sils, and dishes designed to meet the developmental needs of each resident. The dining area must promote a pleasant and home like environment, be attractively furnished and decorated, and have good acoustical quality. It must also be designed and arranged to stimulate maximum self-development, social interaction, comfort, and pleasure, and meet the needs of the residents and the requirements of the programs. Table services should be provided for small groups which include both sexes, and for all who can and will eat at a table, including residents in wheelchairs.

Dining rooms must be adequately supervised and staffed for the direction of self-help eating procedures, and assure that each resident receives an adequate amount and variety of food.

Dining and serving arrangements should provide for a variety of eating experiences, including cafeteria and family style, and the opportunity to make food selections with guidance.

Residents must be provided with systematic training to develop appropriate eating skills, utilizing adaptive equipment where it serves the developmental process. Those with special feeding disabilities will be provided with an interdisciplinary approach to the diagnosis and remediation of their problems, consistent with their developmental needs.

Direct care staff must be trained to utilize proper feeding techniques. Residents must be fed in an upright position and in a manner consistent with their developmental needs. For example, infants should be fed in arms as appropriate. Residents will be fed at a leisurely rate and given enough time for feeding to permit adequate nutrition, promote the development of self-feeding abilities, encourage socialization, and provide a pleasant mealtime experience.

Clothing needs and use. Residents will be trained and encouraged to select and purchase their own clothing as independently as possible, preferably utilizing community stores. They will be allowed to select their daily clothing and to dress themselves, and change their clothes to suit particular activities. Where conditions allow, residents will also be permitted to maintain their clothing by laundering, cleaning, and mending, as independently as possible.

Non-ambulatory residents must be dressed in their own clothing daily, unless contraindicated by written medical orders. For the multi-handicapped, washable clothing will be designed to facilitate training in self-help areas. Clothing for incontinent residents will be designed to foster comfortable sitting, crawling, and/or walking, and toilet training.

Grooming, health and hygiene. Residents will be trained to exercise maximum independence in grooming, health, and hygiene practices, including bathing, brushing teeth, shampooing, combing and brushing hair, shaving, and caring for toenails and fingernails. Each resident will be assisted in learning normal grooming practices with individual toilet articles that are conveniently available to him. Residents will also be regularly scheduled for hair cutting and

styling, in an individualized, normalized manner. Cutting of toenails and fingernails for residents should be scheduled at regular intervals based upon need.

Each resident must have a shower or tub bath daily or frequently enough to maintain sound standards of personal hygiene. The resident's bathing must be conducted at the most independent level possible with due respect for privacy. Clean washcloths and towels must be provided for each individual resident being bathed.

To maximize program effectiveness, provisions will be made to furnish, maintain in good repair, and to encourage the use of dentures, eyeglasses, hearing aids, braces, etc., prescribed by appropriate specialists.

Toilet training. Each resident who does not eliminate appropriately and independently will be engaged in a systematic and regular toilet training program. The program will comprise procedures leading from uncontrolled habits to independent toileting. Records must be kept of the progress of each resident.

Freedom of movement. Except in rare cases, residents should be instructed in how to use and plan opportunities for freedom of movement within and outside the facility's grounds. Multi-handicapped and non-ambulatory residents will spend a major portion of their waking day out of bed. They must also have planned daily activity or an exercise period, and be rendered mobile by various methods and devices. All residents will have planned periods out-of-doors on a year-round basis.

Social relations. During on-campus and off-campus activities, provisions must be made for heterosexual interaction appropriate to the resident's developmental level.

Management of personal affairs. Mentally retarded persons must be trained in the value and use of money and, when appropriate, be permitted self-direction in the possession and spending of money. Residents should be paid for their work on a scale comparable to that of the institutional employee if the quality and quantity of work are also comparable.

Vocational habilitation. Vocation habilitation services must be made available to residents in accordance with their needs. Included in these services will be a vocational evaluation, a written plan to achieve objectives, and implementation of the plan through pre-vocational programs, vocational training, vocational placement, and referral to appropriate sources for other services. In conjunction with job placement, residents will also be provided assistance in related needs such as living arrangements, social and recreation activities, medical services, educational resources, religious activities, and transportation.

Management of undesirable behavior. A written statement of policies and procedures for the control and discipline to maximize the growth and development of residents should be made available to each living unit. Physical restraint should be employed only when absolutely necessary to protect the resident from injury

to himself or others, and should not be employed as punishment, for the convenience of staff, or as a substitute for programming. Seclusion, defined as the placement of a resident alone in a locked room, should not be employed, unless such seclusion meets the requirements set forth for use of physical restraint.

Each facility should have a written policy defining the usage of restraints, the staff members who may authorize their use, and a mechanism for monitoring and controlling their use. Orders for restraints should not be enforced for longer than twenty-four hours. A resident placed in restraints should be checked at least every thirty minutes by a staff member trained in the use of restraints, and a record of such checks should be kept. Mechanical restraints should be designed and used so no physical injury is done to the resident. Opportunity for motion and exercise should be provided for a period of not less than ten minutes during each two hours in which the restraints are employed.

Behavior modification programs involving the use of time-out devices, the use of noxious or aversive stimuli, should be reviewed and approved by the facility's Research Review of Human Rights Committee, and the written plans for such programs should be kept on file.

Restraints employed as a time-out device should be applied only for very brief periods during conditioning sessions, and only in the presence of the trainer. Removal from a situation for a time-out purpose should not be applied for more than one hour and should be used only during program sessions and under the supervision of the trainer.

Mechanical supports used in normative situations to achieve proper body position and balance should not be considered to be a restraint, but should be designed and applied so as to reflect concern for circulation, and allowance for change of position.

Chemical restraint should not be used excessively, as punishment, or for the convenience of the staff, as a substitute for program, or in quantities which interfere with the resident's habilitation program.

As may be seen, the accreditation standards discussed in this section focus upon some of the basic issues dealt with in the **Standards for Residential Facilities for the Mentally Retarded** (i.e., administrative policies and practices; resident living). These portions of the standards have been presented because of their critical relationship to program implementation. The remaining sections of the standards contain other important issues such as staff qualifications and supportive services. Copies of the complete standards document can be obtained from:

Program Director
Accreditation Council for Facilities
for the Mentally Retarded
645 North Michigan Avenue
Chicago, Illinois 60611

Parents should obtain and study copies of the **Standards for Residential Facilities for the Mentally Retarded** so they can become knowledgeable of all standards used in the accreditation of residential facilities for mentally retarded persons. Knowledge and understanding of the standards will be a prerequisite to effective parent involvement in program evaluation and change.

References

ACFMR. **Standards for Residential Facilities for the Mentally Retarded.** Chicago: Accreditation Council for Facilities for the Mentally Retarded, 1971.

Nirje, B. The normalization principle and its human management implications. In: **Changing Patterns in Residential Services for the Mentally Retarded.** President's Committee on Mental Retardation Monograph. Washington, D.C., 1969, pp. 181-195.

Roos, P., Patterson, G. and McCann, B. **Expanding the Developmental Model** (an unpublished paper). Arlington, Texas: National Association for Retarded Children, 1970.

Wolfensberger, W. The origin and nature of our institutional models. In: **Changing Patterns in Residential Services for the Mentally Retarded.** President's Committee on Mental Retardation Monograph. Washington, D. C., 1969, pp. 63-143.